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REVISED

September 21, 2007

To: Supervisor Zev Yaroslavsky, Chairman
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From: William T Fujioka
Chief Executive Officer

REPORT ON EFFORTS TO ENHANCE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT CLAIMING PRACTICES AND IDENTIFICATION OF MENTAL HEALTH SERVICES ACT FUNDING OPPORTUNITIES (ITEM NO. 23, AGENDA OF SEPTEMBER 25, 2007)

On July 17, 2007, your Board requested a report from my office on efforts to enhance Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) claiming practices and to identify any available Mental Health Services Act (MHSA) funding opportunities to ensure that any available funding can be maximized to serve the mental health needs of foster children. The following is our report, which reflects discussions with County Counsel, the Department of Mental Health (DMH) and the Department of Children and Family Services (DCFS).

EPSDT

EPSDT is a comprehensive and preventive child health program for individuals under the age of 21, and has broadened and enhanced mental health delivery services for children. The Department's billings for services rendered to Medi-Cal beneficiaries that have EPSDT Medi-Cal Aid Code status comply with State and federal requirements. These requirements are all directly operated or contracted service providers must: be Medi-Cal certified; verify the client is a Medi-Cal beneficiary; provide a medically necessary eligible Medi-Cal service to the Medi-Cal beneficiary; and submit the claim for the service(s) to County DMH within the State's specified time deadlines. The Department accumulates all submitted Medi-Cal claims in a claims file which is forwarded to the California Department of Mental Health (CDMH) on a weekly basis, who in turn forwards the Department's claim files to the State Department of

Health Services (SDHS) for claims adjudication. The CDMH also checks the adjudicated claims file against the State's Medi-Cal beneficiary eligibility file to ascertain whether the Medi-Cal beneficiary has EPSDT Medi-Cal Aid Code status.

Customarily, CDMH remits the federal financial participation (FFP) and EPSDT - State General Funds (SGF) to the Department for the approved adjudicated claims in 30 to 60 days after the receipt of a SDHS adjudicated claims file. The EPSDT-SGF is calculated by CDMH on the results of the SDHS approved claim lines for Medi-Cal beneficiaries that have EPSDT Medi-Cal Aid Codes. The Department remits FFP and EPSDT-SGF to contractors based upon the SDHS adjudicated claim files.

The following was provided by DMH and shows the EPSDT Medi-Cal Cost History for FY 2003-04 through FY 2006-07. These amounts are as of September 18, 2007 and are subject to change due to the Medi-Cal claiming and settlement cycles.

Fiscal Year	EPSDT-SGF	CGF	FFP	Total
2003-04	123,140,378	33,278,438	167,723,132	324,141,948
2004-05	129,105,914	31,586,801	159,878,763	320,571,478
2005-06	143,106,070	36,086,022	178,409,437	357,601,529
2006-07	143,891,821	35,745,675	179,310,801	358,948,297

EPSDT Audits

Since January 2005, the California Department of Mental Health (CDMH), through the use of a contractor has been responsible for conducting chart reviews of EPSDT services of selected Legal Entities (LE). The initial audits of this program proved to be highly problematic, including the procedural validity of the audit methodology, the use of audit sampling and extrapolation, and the appeal process offered by CDMH. Areas of concern included: the audit methodology applied to LE's with multiple sites for clinical services; extremely stringent documentation requirements, including the allowability of electronic records to satisfy documentation requirements; the disallowance of discharge summaries related to client treatment; and the use of extrapolation of audit results on what where considered very small sample sizes. In addition, the universe of claims from which samples were drawn from was deemed to be far from uniform and not representative of a LE's claims and services, and included the lumping together of services from a wide variety of service functions and modality.

CDMH Information Notice

On December 11, 2006, in accordance with the 2006-07State budget trailer bill and language included in Assembly Bill 1807, and in response to the California Mental Health Director's Association and other stakeholders, CDMH issued Information Notice No: 06-16 which revised the method for auditing entities providing mental health services under the EPSDT Program, and its methods for extrapolating data obtained from these audits. Commencing July 1, 2006 and continuing thereafter, the following provisions were made:

a) CDMH will select statistically valid stratified samples by service function for each entity to be audited.
b) CDMH shall not extrapolate the results of any audit to the full audited service function unless the error rate determined by the audit is five percent or greater. If the error rate is less than five percent, the department shall disallow only the specific claim found to be in error. The extrapolation is to be done within the service function.
c) CDMH, in consultation with stakeholders, shall select an independent statistician to review the sampling methodology and extrapolation methodology used by the department. The statistician shall prepare a public report on the statistical validity of these methodologies. If the statistician determines either methodology to be invalid, the department shall adopt a new methodology, which shall be used by the department only after it is verified by the statistician.

EPSDT Training and Documentation Manual

In addition to the statistical sampling review, CDMH has contracted with the California Institute of Mental Health (CIMH) to develop and provide EPSDT documentation training to counties and provider organizations, as well as develop an EPSDT Chart Documentation Manual on billing and related process associated with operating an effective and qualitative EPSDT Program. The goal of these EPSDT trainings is to strengthen knowledge and practices of chart documentation, identify and reduce common errors, and identify promising clinical practices. To date, CIMH has developed a short-term training program designed to address and reduce the most common errors, as well as improve the quality of clinical documentation. CIMH will conduct training in Southern California on September 19, 2007 and will be attended by DMH, and some contractor staff. DMH staff will then provide necessary training to providers under contract with the department. The EPSDT Chart Documentation Manual can serve as a valuable resource and reference guide, and will provide a key point of direction to EPSDT providers in the documentation of EPSDT services and other EPSDT supplemental specialty mental health services. DMH will notify its contractors of its availability in the trainings it provides to its contractors.

Notification of EPSDT Review

Starting in July 2006, the CDMH provides a four-week advance notice (Announcement Letter) of an EPSDT chart audit. Previously there was a two-week notice of ESDPT audits. This additional lead time will allow both DMH and its providers much needed time for preparing for these audits. It should be noted that the lead time of the chart sample that lists the beneficiaries to be reviewed remained at two-weeks prior to the first day of the review.

Multidisciplinary Assessment Team (MAT) Services and Claiming

A significant issue raised by the Katie A. Panel (Panel) and plaintiff attorneys is whether the County and its contractors will maximize its claiming of EPSDT for MAT services and activities. Per our discussions with DMH and County Counsel, the Panel feels that DMH is not being pro-active enough in pursuing EPSDT reimbursement for these services. Although the MAT assessment is considered by DMH to be valuable in optimizing comprehensive services to a family, not all activities/services that are provided are reimbursable through Medi-Cal, with reimbursements only for services that are medically necessary to assess and treat mental health impairments.

DMH prepared a comprehensive list of claiming guidelines (Attachment) to maximize the claiming of EPSDT / Medi- Cal funds. These detailed directions include the application of appropriate billing codes for the establishment of medical necessity, defines age group parameters and provides directives to avoid EPSDT revenue disallowances. These guidelines were shared with the Katie A. Panel, and changes were made by the department to incorporate panel recommendations into these guidelines. The guidelines are categorized into: Activities with Low Risk of Medi-Cal Audit disallowance; Activities with High Risk of Medi-Cal Audit disallowance; and specific items that are not allowable Medi-Cal services. These non-allowable items include:

a) Clerical Activities such as making appointments, appointment reminders, and photocopying materials (State DMH Letter No 02-07).
b) Travel time to and from appointments with client/collateral when no client contact/collateral is made (State DMH Letter no 02-07).
c) Mental Health clinical assessments for a parent when the MAT agency does not have an open record on the parent. To claim reimbursement for the mental health assessment of a parent, a separate record for the individual parent must be opened at the agency in which parent assessment findings are documented and claimed to Medi-Cal. The parent would them be the individual client being seen by DMH.

Based on discussions with DMH, the department's position is that the items identified as non-allowable should not be claimed to EPSDT. The items identified as high risk, however, are potentially claimable at the discretion of each individual agency. By categorizing these as high risk, DMH is providing notice to providers be aware of the risk of audit disallowance associated with claiming these activities.

DMH Training

The QAB also revised the DMH Child/Adolescent Initial Assessment Form (IAF), aligning it with Multidisciplinary Assessment Team (MAT) scope of work activities to increase the capturing of MAT EPSDT reimbursement activities. The redesign allows staff to easily transfer data from Initial Assessment to the DCFS Summary of Findings document. The DMH Clinical Policy Committee is currently reviewing the document, and it is anticipated that changes, if any, will be minor. In early 2007, 25 MAT Provider agencies attended training on MAT Claiming Guidelines to improve EPSDT claiming performances. Furthermore, in October 2007, 60 MAT clinicians will attend training on MAT Claiming Guidelines, the revised DMH IA forms, and MAT Vignettes in order to further maximize the EPSDT claiming practices.

Since the beginning of 2004, the DMH Birth to Five Program, in association with the Infancy, Childhood and Relationship Enrichment (ICARE) network, has been facilitating the establishment of independent "stand alone" work groups in MAT Services Areas 3 and 6 to increase EPSDT claiming competencies and maximize revenue. This collaboration has been working closely with MAT Program Management, MAT Providers and the DMH QAB to maximize EPSDT claiming with this special MAT age group.

Finally, the Enhanced Specialized Foster Care Corrective Action Plan includes provisions for additional quality assurance staff dedicated to provided EPSDT billing and documentation training and oversight for contract providers who offer MAT services.

Financing Information

In response to the potential use of MHSA funding, it is anticipated that additional growth dollars will be available in FY 2008-09, however at this time this amount has not been identified by the State. DMH will include the appropriate mental health portion of the Enhanced Specialized Foster Care Program to its Stakeholder and planning discussions when determining the use of these dollars. In addition, DMH will work with our office and your offices on planned use of these funds. As previously noted in our August 20, 2007 status report to the Board, there is no change to the current MHSA funding. MHSA funds currently available to DMH are for implementing the Community Services and Supports (CSS) component, and the State-approved MHSA Plan does not include the same services

that are reflected in the County Plan. Therefore, use of currently available MHSA funds would require an amendment to the State-approved MHSA Plan, after a review process by the MHSA stakeholder group. In addition, the MHSA growth funding for FY 2007-08 has already been allocated for existing CSS plans.

While MHSA funds are not currently available for the County Plan, DMH is already providing mental health services to DCFS children funded by $7.5 million in MHSA dollars. This amount represents costs associated with slots under Full Service Partnerships (FSP) for Children and Transition Age Youth (TAY). Under the current MHSA CSS Program, more than 30 percent of the Children's FSP slots are earmarked for DCFS children, as a focal population. While the TAY slots do not specifically earmark slots for DCFS children as a focal population, DMH estimates that approximately 20 percent of the TAY FSP slots are being utilized for DCFS children.

In addition, just this week DMH, DCFS and County Counsel met with the Panel to continue discussions on the Board approved Corrective Action Plan. Although still ongoing, part of these discussions revolved around methods to increase EPSDT reimbursement by moving away from the more traditional ways in which mental health services are delivered. Additional meetings with the Panel are scheduled for October 9th and 10th, and November 1. We will provide another report back to the Board in November to provide outcomes of these discussions.

Along with the above, we will continue our work with DMH and DCFS to explore and identify available funding opportunities to ensure dollars are maximized when serving the mental health needs of foster children. We will include those recommendations in the 2008-09 Proposed Budget submissions for both Departments.

If you have any questions or need additional information, please contact me, or your staff may contact David Seidenfeld of my staff at (213) 974-1457 or via email at dseidenfeld@ceo.lacounty.gov.

WTF:SRH:SAS
DRJ:DS:bjs

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Director, Department of Children and Family Services
Director, Department of Mental Health

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

MULTIDISCIPLINARY ASSESSMENT TEAM (MAT) CLAIMING GUIDELINES

The MAT assessment is considered by the LAC DMH to be valuable in optimizing comprehensive services to a family. However, not all activities/services that contribute to arriving at this comprehensive plan are reimbursable through DMH Medi-Cal. DMH Medi-Cal reimburses only for services that are medically necessary to assess and treat mental health impairments. Even those services that are reimbursable are subject to an auditor's determination that the documentation supports the service rendered. This audit determination is why final payment of even reimbursable services can never be guaranteed.

Activities with Low Risk of Medi-Cal Audit Disallowance **provided the activity is supported by quality documentation**	**Activities with High Risk of Medi-Cal Audit Disallowance** **Items in *bold italics* are not allowable MC services.**
	Clerical Activities such as making appts, appt reminders, and copying materials. (State DMH Letter No 02-07)
Travel time directly connected to contacts with a client/collateral to determine the mental health needs of the client. (State DMH Letter No 02-07)	***Travel time to and from appts with client/ collateral when no client/collateral contact is made. (State DMH Letter No 02-07)***
When a child is currently being seen, whether at a MAT or non-MAT agency, one mental health assessment annually or with a new, clearly delineated presenting problem (see item 3.5).	When a child is currently being seen, whether at a MAT or non-MAT agency, more than one mental health assessment annually in the absence of a new, clearly delineated presenting problem.
When a child is not currently being seen at a DMH/DMH contract provider, a guideline within which medical necessity should be determined is up to two face-to-face contacts with the client (see item 3.3).	When a child is not currently being seen at a DMH/DMH contract provider, more than two face-to-face contacts in the absence of documented medical necessity or without adequate documentation to support the need for additional contacts to establish medical necessity.
Approved psychological testing supported by documentation that establishes the need (see item 4.2).	Routine psychological testing for all assessments.
Collaterals (i.e. caretaker, family) and consultations (i.e. agencies) to obtain client assessment information when guided by the best practice of a preliminary client plan (see items 4.1 and 4.2).	Collaterals and consultations related to the social welfare needs of the child or family and not directly related to obtaining mental health assessment information about the child.
Mental health clinical assessment for a parent when the MAT agency opens a record on the parent.	***Mental health clinical assessment for a parent when the MAT agency does not have an open record on the parent (see item 3.6).***
Targeted case management (TCM) for client referrals and services that are directly related to the mental health needs of the client when guided by the best practice of a preliminary client plan (see items 4.1 and 4.2).	TCM for client referrals that are not directly related to the documented mental health needs of the client. TCM for service and/or treatment needs of collaterals when not specifically linked to the mental health needs of the client.
MAT Team Meeting: Time claimed that is clearly linked to the documentation of the mental health contribution made and/or the mental health information gleaned during the meeting that contributed to the assessment or formulation of the client plan (see item 5.1 with scenario).	MAT Team Meeting: conference time devoted to non-mental health and/or child welfare issues (see item 5.1 with scenario).
	Preparation of the MAT Summary of Findings Report (see item 5.2).

MULTI-DISCIPLINARY ASSESSMENT TEAM PROCESSES

1.0 Referral:

1.1 Prior to beginning a MAT assessment, a client search should be conducted to determine whether or not the child being referred is receiving services anywhere in the system. Should the client be actively receiving services at a MAT agency, the referral for a MAT assessment should be made or forwarded to that agency. If the client is not actively receiving services anywhere in the system, the child can be assessed at any MAT agency.

1.2 MAT assessments shall only be performed by MAT trained agencies/staff. If a child has an open episode in a non-MAT agency, the non-MAT agency must add the MAT agency to the Client Care/Coordination Plan (CCCP) for assessment services. The MAT agency should work collaboratively with the non-MAT agency in completing the MAT assessment.

2.0 Opening/Closing Cases:

2.1 It is LAC DMH policy that client records are not opened prior to a face-to-face contact with the referred client.

2.2 A record may be opened following the first face-to-face contact with the referred client. Medical Necessity does not need to be established prior to opening a record. A record may be opened with Deferred Diagnosis; however, it may not be closed with Deferred. A record may be closed with V71.09 "No Diagnosis on Axis I or II."

3.0 Assessment:

3.1 It is the LAC DMH's current understanding that the interpretation of the Assessment code (90801 or 90802) is a face-to-face procedure, that is, the client must be present.

3.2 No third party payer sets limits on the length of time that can be claimed for a single assessment contact.

3.3 Claiming to Medi-Cal must be discontinued when it is established that Medical Necessity does not exist. It is anticipated that this decision can be made within the first two contacts with the client.

3.4 Other funding sources may be claimed, when available, in the absence of Medical Necessity to complete the MAT.

3.5 When a MAT referral involves a child currently being seen at a DMH/DMH contract agency, in the presence of a new, clearly delineated presenting problem one assessment mental health service (90801 or 90802) may be claimed. **Note:** In the absence of a new, clearly delineated presenting problem, it is assumed that all mental health assessment information specific to a child that is needed for the MAT assessment has already been obtained.

3.6 While DCFS has a focus on the family, DMH must focus on the individual client. In the MAT assessment, each individual child is the DMH client. DMH may consider the impact of the family in the assessment/treatment of the child. Beyond this consideration, parental assessment would not be appropriate for Medi-Cal claims because services must focus on the individual being seen. Only if assessment services of the family are directly related to and focused on the mental health needs of the child may they be billed to Medi-Cal as collateral services. In our current audit climate, these services could still be disallowed despite their importance. **Note:** To claim reimbursement for the mental health assessment of a parent, a separate record for the individual parent must be opened at the agency in which parental assessment findings are documented and claimed to Medi-Cal. The parent would then be the individual client being seen by DMH.

4.0 Other Services During the Assessment:

4.1 Because of the comprehensive nature of the MAT assessment, the LAC DMH considers it to be a best practice to develop and document a preliminary client plan at the time of referral. It should include all people the assessor plans to contact in order to complete the clinical assessment and the relevance of the contacts to the assessment. This preliminary plan will support the use of any appropriate non-assessment code in the Procedure Codes Guide during the assessment period.

4.2 No rule currently exists that support the disallowance of Targeted Case Management (T1017) or Mental Health Services (Collateral-90887, Case Conference-99361, Psychological Testing-96101, 96102, 96103, & treatment codes) delivered prior to Medical Necessity being established although is seems presumptive that these services would not be delivered in the absence of Medical Necessity. With quality notes, these services are currently being allowed. However, State EPSDT Auditors have made statements that these services should not be delivered prior to establishing an included diagnosis and the development of a plan even during the assessment period and, thus, may be disallowed in the future. LAC DMH believes that the implementation of the best practice preliminary plan noted above will help protect against any possible future disallowance of these services.

5.0 MAT Team Meeting and MAT Summary of Findings Report:

While in the LAC DMH system of care each person being assessed for services has his/her own record, the DCFS system of care is family focused. This means that each child in a family who is referred for a MAT assessment will have a record opened on him/her and receive an individual assessment. Generally speaking, most other input (schools, health) is also individual. The MAT Team Meeting and Summary of Findings is intended to bring all of these individual findings together into a family-focused child welfare plan that will likely include mental health services for some members of the family.

5.1 The MAT Team Meeting (Case Conference/Consultation – 99361 or 99362) is an inter-Departmental meeting that includes the family for the purposes of reviewing and discussing findings on each member of the family and formulating both individual and family-focused plans of action in all realms relevant to the family or individuals within it. The mental health findings on each of the children within a family will be discussed at the meeting along with individual health and child welfare findings. DMH staff facilitate the meeting. Only the time of the meeting that is specifically related to the mental health aspects of a child can be claimed to DMH Medi-Cal.

> ***Scenario**: A 2 hr MAT Team Meeting occurs in which a family of 6 children is discussed. All of the children meet Medical Necessity criteria. DMH staff/contract staff take 10 minutes per child to present the mental health assessment and recommendation. Other documentable information regarding mental health issues that impact the mental health assessment and treatment plan for 3 of the children is obtained from other attendees subsequent to the10-minute per child presentation.*
>
> ***Low Risk Claim:** Ten minutes can be claimed to Medi-Cal by the mental health presenter for 3 of the children and 10 minutes plus the time of other documentable information for the other 3 children. Conference documentation time for each child can also be included in his/herclaim.*

5.2 The MAT Summary of Findings Report is prepared by DMH or DMH contract staff as report-writing (90889) after the mental health clinical assessment has been completed on each child in the family. While it includes individual mental health information and recommendations extrapolated from the clinical assessment, it is a DCFS document that addresses child welfare issues beyond the mental health realm. It is intended to guide quality service planning for the family. It usually contributes little or no new information to the mental health clinical assessment of a specific child, but may contribute to the formulation of a comprehensive mental health plan for some members of the family. Because the write-up of the MAT Summary of Findings is a combination of the extrapolation of findings from the mental health assessment and input from other realms regarding child welfare for the benefit of DCFS, the MAT Summary of Findings Report should not be claimed to DMH Medi-Cal.

6.0 Progress Note:

6.1 The progress note is the audit trail. For activities documented on the assessment form, a cross-reference in the progress notes must be made stating which part(s) of the assessment were completed during the session. Documentation/claiming information must include date, procedure code, and face-to-face and other time of all participating staff. The note must state the names of participating staff. If more than one staff participated, the contributions of each staff must be noted.

6.2 If the assessor is obtaining clinical history from a caretaker on more than one child, the assessor should track, within reasonable limits, the time spent gathering and documenting information on each child as noted in the following scenario:

> ***Scenario**: A 30 minute contact with mother of 2 sibs, both being evaluated.*
> ***Claim: (an appropriate claim would not exceed 30 min of face-to-face)***
> - *In Johnnie's Progress Notes – "Gathered information on pre-natal and 0-5 history – see Assessment page 4"; face-to-face 20 minutes, other 10.*
> - *In Sally's Progress Note – "Gathered information on pre-natal and 0-5 history – see Assessment page 4"; face-to-face 10 minutes, other 5 minutes.*